St. Vincent de Paul Pharmacy

Date _____

Patient Information

Every patient must complete this form.

Last Name_____ **First Name**_____ **Initial**_____

Address_____

Phone _____ **Social Security #** _____ **Gender** ☐ Male ☐ Female

Date of Birth (mm/dd/yyyy) _____ **Age Range:** ☐ 0-17 ☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

Race/Ethnicity ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ White ☐ Other _____

Primary Language _____ **Interpreter Needed?** ☐ Yes ☐ No

Education Completed ☐ None ☐ Elementary School ☐ High School/GED ☐ 2 Years College ☐ 4 Years College

Employment ☐ Full-Time ☐ Part-Time ☐ Temp ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other_____

Are you a Veteran? ☐ Yes ☐ No **Do you have a Case Manager?** ☐ Yes ☐ No

If you have a case manager or someone referred you, please list the name of the individual and/or organization:

_____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Information (if applicable)

Last Name_____ **First Name**_____**Initial**_____

Date of Birth (mm/dd/yyyy) _____ **Social Security #** _____ **Gender** ☐ Male ☐ Female

Employment ☐ Full-Time ☐ Part-Time ☐ Temp ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other_____

Is your spouse a veteran? ☐ Yes ☐ No

Other Household Member Information

Total # in Household (including patient): _____

Please use back of page to detail additional family members.

Name	Gender (M/F)	Age	Relationship

St. Vincent de Paul Pharmacy

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Medical and Prescription Information

Health Insurance ☐ Medicare ☐ Medicaid ☐ VA Benefits ☐ Other _____ ☐ None

Please list Medication(s) Needed: _____

_____

_____

Please list any Allergies to medications and your reaction:_____

_____

In the last 12 months, have you been admitted to the hospital or visited an emergency room for your condition?

☐ Yes ☐ No If yes, how many times? _____

How did you hear about SVdP Pharmacy? ☐ Radio ☐ TV/News ☐ Internet/Website ☐ Church [Give Name, if possible]: _____ ☐ Other _____

Consent to Treatment by Volunteers

Please read carefully and add your signature below.

I understand that services I receive from St. Vincent de Paul Pharmacy may be provided by a volunteer who is providing care that is not administered for or in expectation of compensation.

I further understand that Texas Law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1) The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization.
2) The volunteer commits the act or omission in the course of providing health care services to the patient.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.

( ) Myself

( ) The following person for whom I am legally responsible: _____

Print Patient's Name _____ **Date** _____

Patient's Signature _____ **Date**_____
(Or Signature of legal guardian)